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Citation for published version:
O'Neill, J 2019, ''Abortion Games': The negotiation of termination decisions in post-1967 Britain', *History*, vol. 104, no. 359, pp. 169-188. https://doi.org/10.1111/1468-229X.12729

Digital Object Identifier (DOI):
10.1111/1468-229X.12729

Link:
Link to publication record in Edinburgh Research Explorer

Document Version:
Publisher's PDF, also known as Version of record

Published In:
History

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Download date: 07. May. 2023

History
The Journal of the Historical Association
History

‘Abortion Games’: The Negotiation of Termination Decisions in Post-1967 Britain

JANE O’NEILL
University of Edinburgh

The 1967 Abortion Act placed the responsibility for determining the appropriate grounds for a termination with two medical practitioners. This assessment, to be made ‘in good faith’, hinged on the doctor’s interpretation of the wording of the Act and how widely they defined the potential ‘risks’ of continued pregnancy.[1] This responsibility could be troubling for doctors, who were being asked to use their medical expertise to determine what many considered to be a non-medical matter. Doctors varied, both between and within localities, not only in their interpretation of the terms of the Act but also in their ethical and personal attitudes to abortion and to women who might find themselves in this situation. While some doctors adopted a more liberal policy, based on the woman’s wishes, others felt a firm conviction to interrogate the patient’s reasons and perhaps persuade her to take a different course of action. This article focuses on the relationship between doctors and women seeking abortions following the passage of this Act, which placed doctors in a position of having to determine which cases were appropriate and deserving, creating a situation which some have argued facilitated performance and ‘game playing’.[2]

The individuals involved in these decision-making processes may have had differing perspectives or objectives, and while these were sometimes overt it was often mooted by both doctors and reproductive rights campaigners that elements of concealed strategizing or performance might be present in these negotiations. Instead of adopting outright persuasion, doctors could distance themselves from the decision-making process; for instance, general practitioners could refer their patient without including a recommendation either way, or make the referral to a gynaecologist who was known to be either particularly liberal

This work was supported by the Arts and Humanities Research Council as part of the project ‘The Abortion Act (1967): a Biography’ [grant number AH/N00213X/1].

[1] Abortion Act, 1967.

[2] I. M. Ingram, ‘Abortion Games: an inquiry into the working of the Act’, *The Lancet*, 298/7731, 30 Oct. 1971, pp. 969–70; British Pregnancy Advisory Survey [hereafter BPAS], *The Abortion Hurdle Race: The Role of the Doctor as a Taker of Abortion Decisions* (London, 1975).

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or particularly stringent, making the decision a somewhat foregone conclusion. They could delay appointments, or approve the procedure only if sterilization was also agreed to, in order to put the woman off or encourage her to look elsewhere.[3] Women seeking terminations, on the other hand, were often aware that certain circumstances or scenarios were more likely to gain sympathy than others, and might tailor their stated reasons for seeking termination accordingly. A mother struggling with multiple children already, or a 'nice girl' in unfortunate circumstances who exhibited remorse, were often looked upon with more understanding than someone who had apparently failed to demonstrate responsibility by using contraception effectively, and particularly someone who required more than one termination.[4] This knowledge might encourage the presentation of particular narratives, and in turn cause doctors to be wary of being told something that fitted too closely to what they expected or needed to hear.

Contemporary studies of abortion practice showed clearly that this process of negotiation and assessment varied significantly, contributing to divergent abortion figures and experiences of women seeking terminations both within and between regions across Britain. The way the medical interview functioned in practice will be explored through an analysis of medical and sociological studies of abortion practice in the first two decades the Act was in operation, and through the testimonies of healthcare professionals involved in decision-making and of women seeking terminations. Despite sustained and increasing criticism, and numerous attempts to change the law over the past five decades, the need for two doctors to certify appropriate grounds has remained in place for fifty years. Though the legal situation has not changed, medical and lay perceptions of the purpose and function of the medical interview have developed considerably across this time, and the degree to which doctor–patient interactions and the making of termination decisions has changed in practice as a result will be considered.

Under the terms of the Act, in order to certify grounds for termination two medical practitioners have to agree in good faith that continuing the pregnancy would involve greater risk of 'injury to the physical or mental health of the pregnant women or any existing children of her family', or that there is 'substantial risk' of serious foetal anomaly. In making this judgement they can take into account 'the pregnant woman's actual or reasonably foreseeable environment'.[5] In most cases the two doctors would be the patient's general practitioner and the consultant gynaecologist who would undertake the termination, but women might also be referred to and assessed by other hospital doctors, psychiatrists, family planning doctors, medical social workers, and pregnancy advisory service doctors and counsellors, in an extended 'interviewing process'.

[3] See the works cited in n. 2.
[4] Sally Macintyre, *Single and Pregnant* (London, 1977).
[5] Abortion Act.

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The Act was commended by many doctors at the time it was passed for being 'permissive' and yet 'in no way obligatory', due to its provision of a conscientious objection clause which ensured that no doctors would be forced to undertake the operation, except to save a pregnant woman's life.[6] While the terms of the Act were 'deliberately vague', leaving considerable scope for interpretation and discretion, it stopped well short of abortion 'on demand' in placing the responsibility for the decision definitively with the medical profession and not the pregnant woman.[7] The Act was passed primarily for public health reasons, to halt criminal abortions and provide doctors with legal protection from prosecution under certain circumstances, and control the provision of abortion by bringing women 'out of the backstreets and into contact with their GPs'.[8] In fact, one aim or desired consequence of the Act was to reduce numbers of terminations through promoting and legitimating contact between women experiencing crisis pregnancy and a reasoned and reassuring doctor. During the debates on his Bill, David Steel asserted that 'in many cases' the effect of its introduction would be fewer abortions, since being able freely to consult the family doctor could provide reassurance and 'guidance' to a patient who would otherwise seek a backstreet abortion, helping and encouraging her to continue with the pregnancy instead.[9]

In the early years of the Act, some compared the decision to place the responsibility with two doctors favourably with systems operating in other countries, such as the Scandinavian 'tribunal procedure' which reportedly resulted in significant delays and discouraged women from seeking legal abortion.[10] Another benefit noted by some was that being granted a termination by two doctors might validate women's own decisions, positioning their reasons as 'socially acceptable' and therefore lessening 'the guilt and self-recrimination that a few women feel'.[11] Writing in 1971, consultant psychiatrist Hordern felt that 'many women find comfort in realising that it is a considered decision, taken by two independent medical practitioners in light of the total situation, and that it is not being performed merely because they (the patients) are worried or are evading their responsibilities'.[12] Such a construction

[6] S. J. Macintyre, 'The medical profession and the 1967 Abortion Act in Britain', *Social Science and Medicine*, 7/2 (1973), pp. 121–34, at p. 129.
[7] Sally Sheldon, *Beyond Control*: *Medical Power and Abortion Law* (London, 1997), p. 59; Macintyre, 'The medical profession', p. 131.
[8] F. Amery, 'Solving the "woman problem" in British abortion politics: a contextualised account', *British Journal of Politics & International Relations*, 17/4 (2015), pp. 551–67; Sheldon, *Beyond Control*, pp. 17, 26.
[9] David Steel MP, HC Deb, 22 July 1966, vol. 732, col. 1067.
[10] P. Diggory, J. Peel and M. Potts, 'Preliminary assessment of the 1967 Abortion Act in practice', *The Lancet,* 295/7641, 7 Feb. 1970, pp. 287–91, at p. 291.
[11] J. Morton Williams and K. Hindell, *Abortion and Contraception: A Study of Patients' Attitudes* (London, 1972), p. 22; Anthony Hordern, *Legal Abortion: The English Experience* (Oxford, 1971), p. 90.
[12] Hordern, *Legal Abortion*, p. 90.

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could imply that a decision taken by a pregnant woman would not be a 'considered' or responsible one, and this indeed follows the binary model laid down in the Act. In putting the decision in the hands of doctors, the Act created a situation where doctors were characterized as responsible and rational actors, while pregnant women were by extension irresponsible and irrational, insufficiently 'stable or rational to make important reproductive decisions'.[13] While some doctors supported a woman's right to choose and prioritised her wishes when making their assessment, others felt strongly that she was in need of an expert to assess and diagnose what was best in her particular situation. Some doubted that a woman in such a 'predicament' would understand 'what was in her best interest' and considered that a woman's wishes might be different from her 'needs'; fearing that 'by making abortion too readily available we do little but relieve the patient's immediate suffering for a short time and thus do her no real service'.[14]

However, from the earliest days of the Act some doctors expressed concern at the responsibility that had been placed on their shoulders, believing that the Act offered confusion as well as flexibility, and potentially created difficulties for doctors and for the doctor–patient relationship. Davis and Davidson have argued that policy-makers had deflected responsibility on to the medical profession, many of whom accepted the resulting 'medicalization' of abortion reluctantly, at least at first.[15] Consultant gynaecologists, who had to perform the termination and take legal responsibility for it, might find deciding whether or not to do so a grave and 'onerous task' that had nonetheless to be taken quickly in an 'emotion-charged situation'.[16] Some feared the pressure of trying to make an evaluation 'while under considerable pressure in terms of time, stress, and emotional atmosphere, yet at the same time giving the patient the feeling that the investigation is disinterested and thorough'.[17] Some felt that their medical training had not prepared them for making decisions of this nature, noting that the Act gave the medical profession 'considerable freedom to decide' but only 'vague criteria' to follow, meaning that doctors were 'thrown into an unknown sea' with 'only their own personalities, experiences, codes of ethics, religious scruples' to guide them.[18]

In 1971, the consultant psychiatrist Ingram wrote a piece for *The Lancet* titled 'Abortion Games', in which he applied Eric Berne's 'game

[13] Sheldon, *Beyond Control*, pp. 20, 24–5.
[14] David Tunnadine and Roger Green, *Unwanted Pregnancy: Accident or Illness?* (Oxford, 1978), p. 4; Norah M. Cogan, 'Account of the environment: a medical social worker looks at the new abortion law', *British Medical Journal*, 5599/2, 27 April 1968, pp. 235–6, at p. 236.
[15] G. Davis and R. Davidson, ' "A Fifth Freedom" or "Hideous Atheistic Expediency"? The medical community and abortion law reform in Scotland, c. 1960–1975', *Medical History*, 50 (2006), pp. 29–48, at pp. 46–8.
[16] M. Brudenell, 'Foreword', in Hordern, *Legal Abortion*, p. xi.
[17] Cogan, 'Account of the environment', pp. 235–6.
[18] Tunnadine and Green, *Unwanted Pregnancy*, p. 2.

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theory' to the interactions and decision-making processes involved in determining access to abortion.[19] Ingram expressed a deep discomfort with being 'obliged to give opinions' on matters he considered 'non-medical' and felt that the 'ambiguity' of the Act disturbed both doctors and patients, leading to 'a fear of decision-making and to game playing'.[20] In his article, Ingram outlined the concealed motives behind these interactions and potential strategies available to all actors involved. General practitioners could distance themselves from decision-making by referring the woman in question to another doctor without advocating for one outcome or another, or they could appear to do so but pass the decision to a gynaecologist who had a particular reputation for either approving or rejecting termination requests. Thus they could conceal their judgement and avoid a confrontation with the patient. Gynaecologists might delay appointments until the pregnancy was too advanced to terminate (a game he called 'Waiting List'), or might agree to undertake the procedure only if the patient also agreed to a sterilization.[21]

In having to navigate these various doctor 'games', Ingram likened the process of obtaining an abortion from the woman's perspective to an 'obstacle race'. In a similar fashion, Lafitte of the British Pregnancy Advisory Service spoke of it as an 'abortion hurdle race', where the hurdles women had to overcome were first the GP, and then the consultant gynaecologist.[22] Tensions were possible between doctors and women seeking abortions if their interpretations of the situation did not correspond. The potential for this could lead to a wariness of the others' motives, and create a situation where it might in fact be logical to conceal one's strategy and put on a performance, in order to achieve the desired outcome. Ingram points to logical reasoning that might encourage a woman to do this, noting that 'honesty may not be rewarded'; 'The intelligent woman who weighs her life situation and decides rationally and calmly that termination is necessary – that is, plays no games – is less likely to succeed than her more emotional sister who chooses to play "Psychiatric case" and produce the symptoms that the doctor seeks to justify termination.'[23] Therefore the Act and the interactions it proscribes could become a self-fulfilling prophesy, as women might in fact be incentivized to present as irrational and disordered in order to be granted an abortion.

[19] Ingram, 'Abortion games'; Eric Berne, *Games People Play: The Psychology of Human Relationships* (London, 1964). For further discussion of the 'games' outlined by Ingram and their effect on the geographical disparity of abortion provision in Britain, see Gayle Davis, Jane O'Neill, Clare Parker and Sally Sheldon, 'All aboard the "Abortion Express": geographic variability, domestic travel, and the 1967 British Abortion Act', in Christabelle Sethna and Gayle Davis (eds), *Abortion Across Borders: Transnational Travel and Access to Abortion Services* (Baltimore, MD, forthcoming 2019).
[20] Ingram, 'Abortion games'.
[21] Ibid.
[22] BPAS, *Abortion Hurdle Race*.
[23] Ingram, 'Abortion games', pp. 969–70.

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While doctors did not necessarily agree with Ingram,[24] some echoed his findings, noting that although 'he approached the subject in a lighthearted manner, his analysis of the way by which the doctor tries to avoid making positive decisions about abortion are nonetheless true'.[25] There are numerous other examples of doctors referring to the legally necessary medical interview as a 'pretence' or 'charade', because the pregnant woman is required to perform a specific role in order to meet the recognized legal grounds for termination. The gynaecologist Peter Diggory wrote of it in these terms in 1975, feeling that it was 'humiliating and degrading' for a woman to have to 'exaggerate her distress' in order to demonstrate adequate grounds for abortion: 'if I'm faced with a girl wanting an abortion why do I have to test how distressed she is? All I get is a charade played out for me.'[26]

The 'games' or scenarios set out by Ingram and others can be identified again and again in the various studies of abortion practice which proliferated in the decades following the Act's introduction, no doubt due to its immediate and ongoing controversy. These highlight the significance of women's interactions with their doctors and indicate how much control the doctor had over the situation, potentially dominating the interaction and controlling the outcome. They also give useful indications of the criteria doctors used in decision-making, allowing an examination of which categories of patient were viewed as sympathetic or alternatively problematic. While certain trends can be clearly identified, ultimately the scope for individual interpretation by doctors resulted in a high degree of variability. Some did not feel the need to exert their own views or judgements by adopting persuasive tactics; however, as Jeffrey Weeks has noted, others were 'far from being neutral servants of their patients'.[27] Doctors had a significant impact on the outcome and experiences of patients seeking terminations, even when they did not overtly engage in persuasion. Sally Sheldon notes that even a kind and sympathetic doctor might 'deploy power' over the pregnant woman by 'influencing her course of action, rather than facilitating her arrival at her own decision' and that the system of legal regulation inscribed by the Act left her 'in a particularly weak position to counteract the exercise of such influence'.[28] Sally Macintyre's 1970s study of single and pregnant women in Scotland illustrates how clearly the attitudes and advice of doctors could set the parameters of the medical interview, and therefore the options open to young pregnant women. Only half the women interviewed knew without

[24] In a subsequent *Lancet* issue Dugald Baird criticized Ingram's portrayal of the Act and its interactions between doctors and patients as inappropriate, finding 'nothing fundamentally wrong' with the Abortion Act, though he did assert that 'problems' arose in the way it was applied by doctors. Dugald Baird, 'Abortion games', *The Lancet*, 298/7734, 20 Nov. 1971, p. 1145.
[25] Eleanor M. Briggs and Alison E. Mack, 'Termination of pregnancy in the unmarried', *Scottish Medical Journal*, 17/21 (1972), pp. 399–400, at p. 399.
[26] Peter Diggory, *Guardian*, 6 Feb. 1975.
[27] J. Weeks, *Sex, Politics and Society: The Regulation of Sexuality since 1800* (Harlow, 1989), p. 260.
[28] Sheldon, *Beyond Control*, p. 67.

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their doctor mentioning it that legal termination was an option, which is significant because only two of the GPs interviewed reported that they discussed all the available options including termination.[29] This placed the onus on women to introduce the discussion. The Lane Committee on the Working of the Abortion Act (1971–4) found similarly that the option of termination was not necessarily discussed by GPs, and also that in particular young women were reluctant to approach their GPs in the first place, fearing negative attitudes, or perhaps that they might inform their family.[30]

Examples of outright persuasion were not uncommon. One of the doctors interviewed by Macintyre asserted that he was able to persuade the 'majority of girls, those I've known since they were children' to get married rather than abort, stating that although occasionally he did have patients 'demanding termination', 'most can be talked out of it'.[31] Other studies also found that a long-standing relationship with a doctor increased the likelihood that the patient could be persuaded; Tunnadine and Green found that in doctors who had a principled position either for or against termination, a 'good doctor–patient relationship' would lead to the 'convertability of the patient to his ideas and she will carry out his instructions'.[32] Allen's 1980s study suggested that young people were particularly vulnerable to being persuaded and 'overpowered' by doctors, and more mature patients sometimes felt they had to be very firm in their convictions in order to receive the outcome they wanted: 'You know what little demi-gods doctors are … I felt I had the power to think for myself and not be influenced by him.'[33] Many of the women Allen interviewed reported what they felt were attempts to override and intimidate them, one recounting that 'He tried to make me feel like a six year-old with no opinions. Everything I said he twisted to have another meaning' and in another case, 'he was telling me my brain had made a mistake and I really wanted to keep the baby … He was using people who can't have children to get at me'.[34] Half of the medical professionals that Allen interviewed reported that they would 'attempt to dissuade a woman from abortion', with GPs most likely to do so. Mirroring Ingram's concerns regarding referral, the GPs were likely to say that they would make a referral without supporting the request, and almost three quarters asserted that 'there were circumstances in which they would' dissuade women from abortion.[35]

[29] Macintyre, *Single and Pregnant*, pp. 93, 74–5.
[30] *Report of the Committee on the Working of the Abortion Act*, vol. III, Cmnd. 5579 (London, 1974), p. 76; BPAS, *Abortion Hurdle Race*.
[31] Macintyre, *Single and Pregnant*, p. 75.
[32] Tunnadine and Green, *Unwanted Pregnancy*, p. 144.
[33] Isobel Allen, *Counselling Services for Sterilisation, Vasectomy and Termination of Pregnancy* (London, 1985), p. 164.
[34] Ibid., pp. 169–70.
[35] Ibid., pp. 284–5.

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As well as revealing great variation in the attitudes of doctors consulted, such studies identified particular trends in terms of which categories of patient were more likely to be accepted for termination, and which situations would elicit the most sympathy. Some doctors stated openly that 'Sympathy – or lack of it – often determined the decision that was made'.[36] While doctors referred to various practical criteria in coming to their decision, their assessment of these was subject to their own personal interpretation, and in some cases moral judgements. Numerous studies, including one in Wessex in 1980, found that though gynaecologists might refer to the same criteria when coming to a decision, the assessments they made as to the significance of these 'were more of an individual matter'.[37] Extremes of age and perceived intelligence usually merited consideration, as did the circumstances of conception and the pregnant woman's relationship with her sexual partner.[38] Key topics raised by doctors in order to help make their decision included the possibility of alternatives to abortion (with marriage almost always raised with single women), the pregnant woman's home background, her education or career, her relationship with the putative father, and her sexual and contraceptive history.

Women seeking terminations might be viewed and treated very differently by doctors according to their age, marital status and sexual history. In a 1982 *Glasgow Herald* article on barriers to treatment, a West End GP noted the difficulty he had in getting his patients approved at hospitals in the area: 'Sometimes we manage to get a termination locally for women in their forties with large families but hardly ever for young unmarried girls.'[39] Reaffirming this depiction, the Chairman of the gynaecological department at the local hospital stated that he found performing abortions 'very distasteful', and that 'it is very difficult to terminate a pregnancy without good reason … I am not prepared to carry out the operation on a young unmarried woman just because it would be inconvenient for her to have the baby.'[40] The plight of the young single woman is highlighted in numerous other studies from the 1970s and 1980s. Allen's large English study found 'evidence of much less sympathy on the part of GPs towards the younger girls', noting that married, divorced, widowed and separated women, and women with children, were much more likely to find their GPs helpful.[41] Although married women appeared to be treated more sympathetically regardless, the most sympathy was reserved for those who were older and

[36] Discussing views expressed at a symposium on the working of the Abortion Act held in February 1969, Hordern, *Legal Abortion*, p. 116.
[37] J. R. Ashton, K. J. Dennis, W. E. Waters, Audrey Chamberlain, R. G. Rowe and Maggie J. Wheeller, 'The Wessex abortion studies: II, attitudes of consultant gynaecologists to provision of abortion services', *The Lancet*, 315/8160, 19 Jan. 1980, pp. 140–2, at p. 140.
[38] Hordern, *Legal Abortion*, pp. 86–90.
[39] *Glasgow Herald*, 10 Aug. 1982.
[40] Ibid.
[41] Allen, *Counselling Services*, p. 162.

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already had completed families.[42] Hammil and Ingram's 1974 Glasgow study of abortion decisions found similarly that those recommended for termination tended to be older, married and to have children. When discussing the reasons doctors in their study did not agree with or approve terminations, they found that 'the hard core of dissent is the single girl' and that 'this group provokes the most moralistic response from the profession'. Comparing their results with two earlier large-scale studies of termination practice conducted in London and Glasgow, they concluded that 'whatever the degree of "liberality", the core of refusals is formed by young single women pregnant for the first time' and that this was the group that was deemed 'most controversial' and most often terminated privately.[43]

In order to navigate these particularly censorious judgements, then, young single women seeking terminations had to be particularly skilled in convincing doctors that they deserved an abortion. One of the most successful narratives according to Macintyre's study was that of 'nice girl who made a mistake', and in order to be classified as such doctors looked for 'evidence that they had tried to use contraception, the account (if believed) that intercourse had taken place only once when drunk or under pressure, lack of evidence of promiscuity, and a demeanour of shame or regret in the consultation'.[44] In such circumstances, a woman might be regarded as a good girl who had been unlucky or made a mistake – though marriage would be considered the more appropriate outcome if the relationship was sufficiently stable. On the other hand, if women were 'believed to have slept only with casual acquaintances or strangers, they were seen as bad, promiscuous girls who did not deserve an abortion'.[45] Similar language and practices are present in numerous studies, with one of Williams and Hindell's interviewees stating 'I convinced the consultant I wasn't the type who sleeps around and deserves it.'[46]

Another group that faced particular difficulties, often overlapping with the first, were women with repeat unwanted pregnancies. These requests for termination often engendered the most judgemental responses. Hordern noted in 1971 that such cases were 'difficult to assess' but that repeated unplanned pregnancies were 'not uncommon in the impulsive, the psychopathic and the unintelligent'.[47] Allen noted numerous instances in her 1980s study of doctors warning women (particularly young women) who came in for abortions that they would not be seen a second time.[48]

[42] Ibid., p. 272.
[43] E. Hamill and I. Ingram, 'Psychiatric and social factors in the abortion decision', *British Medical Journal*, 1/5901, 9 Feb. 1974, pp. 229–32, at p. 231.
[44] Macintyre, *Single and Pregnant*, p. 85.
[45] Ibid., pp. 74–5.
[46] Williams and Hindell, *Abortion and Contraception*, p. 23.
[47] Hordern, *Legal Abortion,* p. 90.
[48] Women quoting statements that doctors made to them: 'We only allow one mistake. We don't bother with the next one. We just won't do it' (Allen, *Counselling Services*, pp. 167, 170–1).

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Macintyre noted that the 'reluctance of gynaecologists to terminate the pregnancies of single women who have had previous abortions is still often based on the concepts of deservingness and undeservingness'.[49] Doctors seemed wary of inadvertently appearing to condone the use of abortion as contraception, which was how they tended to interpret repeat unwanted pregnancies. The case of a seventeen-year-old with learning difficulties living in an overcrowded home who, despite a supportive recommendation from her GP was refused a termination from a hospital consultant due to her having had a termination the previous year, was reported in the press. The hospital consultant had asserted that 'abortion should not be used as a means of contraception' and while her GP agreed he felt that this response lacked compassion and was inappropriate in these particular circumstances: 'what the girl needed was immediate help and careful contraceptive education'.[50] The consultant had made a judgement that she had shown a pattern of irresponsible behaviour, and therefore did not 'deserve' an abortion, and because of this she was denied help despite the difficulty of her situation.

Perceived class and educational level often appeared significant in determining the likelihood of a woman obtaining an abortion, with the outcome being less likely 'the lower their social class and the poorer their education'.[51] Ingram noted two reasons that this was likely to be the case: firstly because similarity in class between doctor and patient encouraged empathy ('Doctors sympathise more readily with the situation of those girls who might easily be their daughters') and also because middle-class women tended to be 'more knowledgeable about the law, better able to put their case across convincingly, and more skilled in doctor/patient games'.[52] Hence they had less need to manipulate the medical interview, though they were also more likely to be able to do so convincingly if necessary. Many studies of abortion supported this contention. For instance, the Lane Committee found that working-class women were less likely to be accepted for termination and significantly more likely to face delays, noting that this difference could not be explained simply by their relative lack of recourse to private clinics.[53] The needs of middle-class, educated women in skilled jobs were often seen to be more pressing than those of their sisters in semi-skilled and unskilled work.[54] Hordern put this particularly starkly: 'A woman of low socio-economic status in an unskilled or semi-skilled job may tolerate an unwanted pregnancy better than her counterpart in a responsible professional job; the latter, being higher in the social scale, has farther to fall.'[55]

[49] Macintyre, *Single and Pregnant*, pp. 74–5.
[50] *Glasgow Herald*, 10 Aug. 1982.
[51] BPAS, *Abortion Hurdle Race*.
[52] Ingram, 'Abortion games', pp. 969–70.
[53] *Report of the Committee*, pp. 14, 33.
[54] Roger Davidson and Gayle Davis, *The Sexual State: Sexuality and Scottish Governance, 1950–80* (Edinburgh, 2014), p. 114; Macintyre, 'The medical profession', p. 132.
[55] Hordern, *Legal Abortion,* p. 87.

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The period of gestation could also be significant in decision-making, as a mitigating factor for any of the criteria discussed above. Numerous studies showed that doctors might agree to terminate for a greater range of reasons earlier on in the pregnancy, when the procedure was more straightforward. For instance, a 1974 investigation found 'an informal agreement' between gynaecologists and psychiatrists not to recommend termination after twelve weeks 'except for compelling reasons', and a 1980 study of gynaecologist attitudes in Wessex showed a dramatic decline in the willingness to terminate on socio-medical rather than strictly medical grounds after twelve weeks' gestation.[56] This indicates that women were much more likely to obtain an abortion if they presented early enough, and also illustrates how 'Waiting List' games, highlighted by Ingram, could be so powerful in influencing the outcome of termination decisions. The Lane Committee reported in 1974 that GPs 'might have deliberately adopted delaying tactics in the hope that pregnancy would be accepted, or that it would be too late to get an abortion'.[57] It could be difficult of course to determine whether appointments were delayed due to pressure on resources or doctor ambivalence, but women who faced delays often felt that this was deliberate.[58]

These studies clearly demonstrate evidence for Ingram's assertion that the medical interview necessitated by the Act appeared to encourage 'game playing' and performance from both doctors and women seeking terminations. Each might conceal the motives and reasoning behind their behaviours, and be suspicious of the words and actions of the other. Williams and Hindell found that the women in their study had both overt and covert reasons for seeking terminations; the overt reasons were the 'respectable' ones put forward to doctors 'in order to obtain the abortion', and were shaped by their expectations of what would be the most 'acceptable' reasons according to the medical profession and society at large. For example, their respondents 'tended to believe that desertion by the father was a particularly acceptable reason … and a few confided that they had claimed desertion by the boyfriend in order to obtain the abortion when it was not true'.[59] A well-documented way in which women could tailor their narratives better to fit doctor expectations of attempted 'responsibility' was through stories of contraceptive failure. Women's testimonies sometimes revealed explicitly how they might turn an everyday situation in which unwanted pregnancy might result ('we'd run out of durex and I, at least, knew it was risky') to a sympathetic story in which they felt they might be seen as more 'deserving': 'The story I later recounted to various doctors was rather different as I soon learnt that this type of "irresponsibility" is just the thing that doctors think should be

[56] Hamill and Ingram, 'Psychiatric and social factors', p. 230; Ashton et al., 'Wessex abortion studies', p. 141.
[57] *Report of the Committee*, p. 76.
[58] See examples cited in Colin Francome, *Abortion Practice in Britain and the US* (London, 1986), p. 55; Williams and Hindell, *Abortion and Contraception*, pp. 18–19.
[59] Williams and Hindell, *Abortion and Contraception*, pp. 11–13.

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punished by unwilling childbearing. They react much better to sad tales of contraceptive failure.'[60]

This of course did not mean that women's stories would be believed. Doctors were aware that 'ideas about "the type of case most likely to elicit sympathy from a GP" were prevalent in the lay community' and were therefore wary of fabricated or embroidered stories that they felt might be designed to elicit sympathy. Macintyre found that several GPs in her study were 'sceptical about claims of accidental or occasional intercourse', believing these might be an 'attempt to appear respectable and to blame the pregnancy on bad luck rather than bad behaviour'.[61] These GPs based their assessment on 'inferred moral character' from the woman's sexual and contraceptive history, 'how well they thought they knew' the patient and 'whether they regarded them as manipulative'.[62] Several doctors appeared to view patient information on contraceptive history as likely to be fabricated; one study noted that the 'evidence on contraceptives must be treated with reserve, for it is much easier to say that contraceptives were used and failed than to admit they were not used' and another that 'bad luck was a far less common occurrence than many of the women would have the doctor believe'.[63] Tunnadine and Green felt that there was 'considerable manipulation by both patient and doctor to gain the ascendency' in these interactions, and that a patient in 'desperate straits' would go to 'any lengths in furtherance of her goal' and 'will order, cajole, wheedle, or use any device which will suit her purpose'.[64] In some circumstances doctors thought that women might 'exert moral pressure' by threatening suicide (sometimes described as 'blackmail').[65]

The variability resulting from these individual interpretations was widely recognized. A 1973 Aberdeen study found that it was not possible to 'reach a common policy' on termination decisions because 'the gynaecologists differed so much in their evaluation'.[66] Women seeking abortions were also well aware that 'abortion was easier for some than for others depending upon their circumstances and the attitudes' of the doctors consulted, and 'tended to feel that obtaining an abortion was largely a matter of luck'.[67] While some doctors might exert pressure on the pregnant woman to follow their own interpretation, sympathetic

[60] 'Liz' in Brent against Corrie Pamphlet Group, *Mixed Feelings: Ten Women Talk about Their Own Experience of Pregnancy and Abortion* (London, 1980), p. 28.
[61] Macintyre, *Single and Pregnant*, p. 81.
[62] Ibid., p. 83.
[63] M. Clark, I. Forstner, D. A. Pond and R. F. Tredgold, 'Sequels of unwanted pregnancy: a follow-up of patients referred for psychiatric opinion', *The Lancet*, 292/7566, 31 Aug. 1968, pp. 501–3, at p. 501; Tunnadine and Green, *Unwanted Pregnancy*, pp. 32, 106.
[64] Tunnadine and Green, *Unwanted Pregnancy*, pp. 105–6.
[65] Hordern, *Legal Abortion*, pp. 81–3. This had long been recognized as a possible persuasive tactic, with evidence of doctors coaching women to stress the risk of suicide in order to obtain abortion being discussed in the Committee stage of the Bill that became the Abortion Act, see K. Hindell and M. Simms, *Abortion Law Reformed* (London, 1971), p. 183.
[66] Macintyre, *Single and Pregnant*, p. 23.
[67] Williams and Hindell, *Abortion and Contraception*, p. 18.

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doctors might attempt to assist women by helping them shape their narratives to fit the terms of the Act, ensuring their reasons mapped on to the legal criteria. The interview with the psychiatrist Dr Bloom recorded in the largely discredited study *Babies for Burning* provides a useful illustration of this.[68] Despite over ninety questions being asked in the extended medical interview, the anti-abortion authors Litchfield and Kentish critiqued his effort to shape the answers they gave to fit the criteria of the Act as a 'farce' and as evidence that abortion on demand was being practised by some doctors, at least in the private sector.[69] Indeed, Litchfield and Kentish reported being informed by a number of service providers that their case would not be refused in the private sector, even if they would not stand 'an earthly chance' in the NHS.[70]

NHS doctors might be particularly strict in making their assessment of appropriate criteria for termination due to pressure on resources. The Abortion Act placed significantly increased pressure on gynaecological services which had not been adequately prepared to meet the new demand, and it was recognized from the earliest years that this could 'embarrass' already strained resources and 'lead to difficult decisions regarding priorities for admission'.[71] Comments of gynaecologists in the 1980 Wessex study indicated that pressure on resources might prevent them from operating as liberally as they might wish, with one asserting that 'My personal feeling is very nearly "abortion on demand". I have such a heavy gynae workload that I cannot provide it and am thus forced to be selective.'[72] The private sector was an option for some women, and charitable abortion services which offered terminations at a lower cost also began operating in regions across England and Wales where NHS acceptance rates were limited.[73] Many studies record GPs encouraging women who were able to take this path. While such encouragement was purportedly to eliminate the delay and rigmarole that often characterized NHS abortions, GPs' motives in making this suggestion were not necessarily entirely focused on the well-being of the patient. Allen noted in her 1985 study that in some cases GPs were actively 'trying to put pressure on the woman to go privately if she could afford it', and found some clear instances of doctors exercising their own moral judgements and concepts of 'deservingness' to delimit access via the NHS, such as a GP who told a patient who had been raped by her estranged husband that she could 'try the NHS, but it's not an illness and people

[68] For a fuller discussion of *Babies for Burning* and the subsequent legal proceedings, see Sally Sheldon, Gayle Davis, Jane O'Neill and Clare Parker, 'The Abortion Act (1967): a biography', *Legal Studies* (n.d.), pp. 1–18. doi:10.1017/lst.2018.28.
[69] Ibid.; M. Litchfield and S. Kentish, *Babies for Burning*: *The Abortion Business in Britain* (London, 1974), pp. 80–9.
[70] Sheldon et al., 'Abortion Act'.
[71] Philip H. Addison, 'The Abortion Act 1967', *The Lancet*, 292/7566, 31 Aug. 1968, pp. 503–7, at p. 504; Hordern, *Legal Abortion*, p. 113.
[72] Ashton et al., 'Wessex abortion studies', p. 141.
[73] Sheldon et al., 'Abortion Act'.

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should pay for it if it's a conscience thing. You've made a mistake so you ought to pay for it.'[74]

Ultimately, in many cases, no matter what pressure doctors were under and no matter how the pregnant woman might be able to use covert strategies and performance to attempt to influence the decision, the outcome of the medical interview was a foregone conclusion if the doctor consulted was one who had a firm ethical belief in either supporting the woman's right to choose, or preserving the pregnancy at all costs. Tunnadine and Green explored the means by which a doctor who is firmly 'either for or against performing an abortion' would 'manipulate the situation' by interpreting any account the pregnant woman might give as a confirmation of their own point of view, resulting in a 'Catch 22' situation.[75] They termed this situation 'absurd', though they noted that as 'compensation, many of the women knew with what sort of doctor they were dealing and, therefore, could ensure by selection that they got what they wanted'.[76] This was the key way in which women might be able to circumvent the wishes of doctors who attempted to persuade them to continue with an unwanted pregnancy, but it relied on them having sufficient knowledge of the sympathies of doctors and service providers to whom they had access.[77]

The potential absurdity of this situation had been highlighted by doctors from the earliest years of the Act. As early as 1968, some doctors were pointing to evidence that 'a determined, desperate woman will somehow abort' regardless of being turned down at her first attempt, and using this to ask: 'If she is so determined, and impervious to her doctor's advice to the contrary, is it then better for him to acquiesce … would not her health be best maintained by leaving the final decision to her?'[78] Numerous other studies revealed that most who were refused did eventually obtain an abortion elsewhere, and also pointed to evidence from follow-up studies indicating that while significant psychiatric complications resulting from terminations of pregnancy were rare, 'cases of depression and appreciable social distress occur in the refused group'. This again pointed to the fact that in spite of the 'careful attempts at informed decision making' on the part of doctors who proffered refusals, 'the bulk of women seeking an abortion achieve their end'.[79]

In this way, time and evidence from follow-up studies of termination outcomes moderated many doctors' viewpoints, and in turn further influenced practice. Hordern was reporting as early as 1971 that a 'majority' of gynaecologists 'slowly came to view termination of

[74] Allen, *Counselling Services*, p. 143; see also Williams and Hindell, *Abortion and Contraception*.
[75] Tunnadine and Green, *Unwanted Pregnancy*, p. 115.
[76] Ibid.
[77] The ability to 'select' a doctor with a favourable viewpoint is by no means certain; with no registered list of conscientious objectors, it is 'normally impossible' for a woman without inside knowledge to predict the outcome of her request. Sheldon, *Beyond Control*, p. 59.
[78] Clark et al., 'Sequels of unwanted pregnancy', p. 503.
[79] Hamill and Ingram, 'Psychiatric and social factors', p. 231.

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pregnancy on psychiatric grounds if not with approval, at least as being justified in many cases'.[80] Some practitioners giving evidence to the Lane Committee asserted that abortion on request was 'in the best interest of the woman'.[81] Many doctors interviewed by Allen in the 1980s spoke of the way their own practice had changed over time. A doctor who described themselves as having undergone 'a very considerable evolution' reported that in the immediate wake of the Act's introduction they had tried, often successfully, 'to counsel and discuss and actually to dissuade', and though at first everyone had seemed 'thrilled' with the decision not to terminate, 'time and time again' circumstances became difficult. After finding that '[t]hose who came back with the fewest problems were the ones where I'd gone along with what they wanted in the first place', this doctor began to centre the woman's wishes in coming to a termination decision.[82] Numerous medical professionals involved in counselling found that because their experience had indicated that 'significant regrets' following terminations were rare, and unwanted children could lead to 'great pain and unhappiness for everyone concerned', over the years 'they had become more ready to accept a woman's request for termination'.[83]

In fact, across this period many doctors were organized in campaigning groups such as Doctors for a Woman's Choice on Abortion (DWCA), founded in Edinburgh in 1976 to support legal change to give women the right to decide whether or not to terminate a pregnancy, believing that the doctor's role should be to provide information.[84] In general terms, medical views appeared to be liberalizing. A 1989 study of gynaecologist attitudes found that 73% agreed with the 'principle of a woman's right to choose, in consultation with her doctor, whether or not to have an abortion'.[85] This suggests that a significant majority of doctors might be basing their decisions on the woman's wishes, with many more feeling able to operate on this basis than was evident in the early years of the Act. More doctors have called openly for a change to the Act to introduce a woman's right to choose, at least in the first twelve weeks, with Paintin advocating in the *British Medical Journal* in 1992 for a change in the law to bring Britain into line with other European countries.[86] Recent studies have indicated that the authority and decision-making power of women is now generally considered paramount, with one finding evidence that doctors sometimes

[80] Hordern, *Legal Abortion*, p. 123.
[81] Ashley Wivel, 'Abortion policy and politics on the Lane Committee of Enquiry, 1971–1974', *Social History of Medicine* 11/1 (1998), pp. 109–35, at p. 125.
[82] Allen, *Counselling Services*, p. 272.
[83] Ibid., p. 344.
[84] Anna Gurun, 'Second-wave feminist approaches to sexuality in Britain and France, c.1970–c.1983', unpublished PhD thesis, University of Dundee (2015), pp. 62–3.
[85] W. Savage and C. Francome, 'Gynaecologists' attitudes to abortion', *The Lancet*, 334/8675, 2 Dec. 1990, pp. 1323–4, at p. 1324.
[86] David Paintin, 'Abortion in the first trimester: give women the right to choose', *British Medical Journal*, 305/6860, 24 Oct. 1992, pp. 967–8, at p. 968.

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try to conceal their legal decision-making role from women in order to avoid giving the impression that they need to be persuaded.[87]

Of course, despite this general trend, the maintenance of the legal situation allowing considerable medical control and discretion has ensured that the practice and experience of termination decisions have remained variable. While a growing majority of Allen's medical interviewees felt that 'It is the woman's decision and it is reasonable that she should be able to achieve it without a harrowing cross-examination', a minority of doctors still appeared to relish the powerful position they were in and use it to dissuade women: 'I'm afraid I make a meal of it … It should be a long discussion covering the grounds – there have to be legal grounds … I distinguish between the legal and right and wrong. It *is* legal, but *I'd* say it's wrong'.[88] Some doctors retained a belief that pregnant women could not be trusted to take responsible decisions, maintaining that the very fact that a woman has come to experience unwanted pregnancy is 'self-evident' proof that she is given to 'impulsive behaviour and sudden changes of mind' which 'must make a doctor wonder as to her stability and maturity'.[89] Tunnadine and Green felt that this 'reinforces the need for the doctor to take the responsibility for the decision, no matter how adamant or persuasive the patient'.[90]

In the later period we can still see evidence of particular categories of women or situations influencing the outcome and experience of termination decisions. Even some self-identifying liberal feminist doctors did not necessarily support a woman's right to choose in all circumstances. Greenhalgh, a London GP who had 'marched and lobbied in support of a woman's right to choose', nonetheless raised the issue in the *British Medical Journal* in 1992 of a situation in which she could not bring herself to sign the form to approve termination – namely a middle-class mother who requested a termination so that her pregnancy would not interfere with a planned skiing holiday.[91] She justified this apparent conflict by saying though she 'did not for a moment dispute her [patient's] absolute right to do what she liked' with regard to her pregnancy, she could not become 'party to the conspiracy' by signing her name to it, asserting that 'I am not a rubber stamp. I am a thinking and feeling professional and I must live with the clinical, and ethical decisions I make. I, the doctor, also have a right to choose.'[92] The idea of supporting a woman's right to choose, but only under certain circumstances, raised debate in succeeding issues of the *British Medical Journal*. Greenhalgh was accused of failing to place principle before prejudice by arbitrarily imposing 'her own inverse poor

[87] Ellie Lee, Sally Sheldon and Jan Macvarish, 'The 1967 Abortion Act fifty years on: abortion, medical authority and the law revisited', *Social Science and Medicine*, 212 (2018), pp. 26–32, at p. 30.
[88] Allen, *Counselling Services*, p. 273.
[89] Tunnadine and Green, *Unwanted Pregnancy*, pp. 116–17.
[90] Ibid.
[91] T. Greenhalgh, 'The doctor's right to choose', *British Medical Journal*, 305/6879, 8 Aug. 1992, p. 371.
[92] Ibid.

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law concept of "the undeserving rich" '. However, it was also recognized that this situation highlighted ongoing difficulties with the Act and its requirement for doctors to take responsibility for the decision, when it was pointed out that a law allowing women termination on request up to twelve weeks would spare doctors such 'embarrassing situations'.[93] Under such a law, the termination decision would explicitly reflect the woman's wishes, and not implicate the doctor and their professional ethics and responsibilities.

Numerous sources including the advice of pro-choice groups aimed at women seeking terminations, the personal testimonies of women who sought and obtained abortions, and further surveys and studies of the later period all point to certain ongoing continuities. The advice that pro-choice groups and publications produced to help women seeking terminations recognized clearly that there might need to be a process of concerted negotiation with doctors, and mirrored some of the 'games' highlighted by Ingram decades earlier. Advice in the 1980s and 1990s still emphasized the variability of doctors' views and practice, and the possible need for women to be proactive, to push for referrals and appointments, and perhaps change doctor in order to get a termination. A National Abortion Campaign leaflet of the period gave detailed information on this to help women who might be put off by doctors or subjected to the 'waiting list'. The leaflet encouraged women to ask their GPs about staff attitudes at their local hospital and push for speedy referral appointments, warning that some GPs 'will not tell you that they do not approve of abortion – they just send you to a gynaecologist they know will refuse you permission' and noting that the final recourse of every woman facing difficulty was to go to a private or charity clinic.[94] The potential for delays, particularly on the NHS, due to the sometimes judgemental or unhelpful actions of medical professionals was consistently raised in pro-choice campaigning materials. Advice in a feminist zine from the early 1990s presented a similar picture, encouraging women to be assertive if they suspected their doctor might be opposed to abortion or using 'delaying tactics', warning women against getting too close to the twelve-week limit for early abortions. Their main takeaway was not to give up or back down in the face of obstruction: 'You will get an abortion if you really want one.'[95]

Women's testimonies also reveal the great disparity of views and sympathies they encountered from various medical professionals. Testimonies of abortion experiences across the decades display remarkable continuities. Seeking an NHS abortion aged sixteen in 1978, Rosalind considered herself 'lucky' her GP was sympathetic, but felt that the gynaecologist she was referred to treated her 'like scum',

[93] Alex Scott-Samuel and James Campbell, 'Letters: The doctor's right to choose', *British Medical Journal*, 305/6853, 5 Sept. 1992, p. 589.
[94] National Abortion Campaign (NAC), *How to Get an Abortion*, undated.
[95] *Harpies and Quines: The Abortion Issue*, 8, Aug./Sept. 1993, p. 18.

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telling her that she had 'fallen by the wayside'. Though consent to operate was given, she felt this was 'reluctant' and 'left his office with a deep sense of shame'.[96] In a testimony collected in 1993, Charlotte recounted numerous obstructive and hostile interactions with medical professionals, having to change her GP due to his anti-abortion views, waiting five weeks in 'sheer hell' to get a termination appointment before facing disapproving hospital staff, and then being sent home with a 'seriously high dose contraceptive pill (due to my obvious irresponsibility)'.[97] These accounts of two young single women across decades show remarkable similarities, revealing ongoing assessments of 'deservingness' related to perceptions of 'responsibility'. Interestingly, both successfully achieved the termination decision they wanted, but still experienced judgement from some doctors, which increased their feelings of guilt. This supports Fran Amery's assertion that the Act's requirement for doctors to act as gatekeepers 'has a disempowering effect on women, whether or not requests for an abortion are granted'.[98] Seeking an abortion as a married thirty-year-old without children, Lucia did not obtain a termination on the NHS, finding that the doctors she consulted did not sympathize with her request for an abortion because they did not view her as a particularly needy case.[99] When the NHS gynaecologist she consulted found she was just over twelve weeks' pregnant, she was informed that it was 'too late' and rushed home distraught, before ultimately paying for an abortion privately and having a positive experience with the clinic staff there.[100]

It appears from evidence of the later period that while developments are evident there are also important continuities. A 1997 survey of NHS abortion services found that the availability of terminations in NHS hospitals was still 'directly related to the willingness of key consultant gynaecologists to carry it out', and also found evidence of doctors 'steering women' to the private fee-paying sector in a process of 'informal means testing'.[101] Certain categories of women seeking abortions were still viewed as problematic, even if these differed slightly from earlier constructions of sympathetic and unsympathetic cases. Duration of pregnancy is still a mitigating factor in making decisions to terminate, with 'later' terminations viewed as a 'problematic decision' by healthcare

[96] NAC and Marie Stopes International, *Voices for Choice: Women Recollect their Experiences of Abortion in Britain 1936–1997* (London, 1997).
[97] *Harpies and Quines*, p. 20.
[98] Amery, 'Solving the "woman problem" ', p. 556.
[99] 'You're thirty, you're married, you've got a job, so what's your problem?', Lucia, describing reactions to her abortion request in 1997, in NAC and Marie Stopes International, *Voices for Choice*, n.p.n.
[100] Ibid. Other studies have recorded women having on average more pleasant experiences in the charity and private sectors, feeling that they received greater sympathy and were given more time and space to talk. Allen, *Counselling Services*, pp. 174–5.
[101] Abortion Law Reform Association, *A Report on NHS Abortion Services* (London, 1997).

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professionals except in cases of diagnosed foetal abnormality.[102] In line with the case discussed by Greenhalgh and Lucia's 1997 experience, Sian Beynon-Jones has found that, rather than the young single girl, the middle-class married and perhaps childless woman seeking abortion might now be looked upon with the least amount of sympathy and the most suspicion.[103]

Under the situation created by the 1967 Abortion Act, women are 'dependent on the goodwill of the doctor to secure access to a termination'.[104] The level of discretion and scope for interpretation this left open to doctors has led to immense variability of experiences according to individual views and practice. Doctors have been able to exercise their professional decision-making power in overt and covert ways to persuade the women of the benefits or otherwise of termination. This has meant that interactions with healthcare professionals might be viewed by pregnant women as 'tests', leading to distrust between women and doctors, and instead facilitating subterfuge and performance. Though many women reported positive interactions with medical staff in the process of having a termination, the need to be seen by and gain approval from (at least) two doctors increased the likelihood of women encountering negative and judgemental medical reactions.

This very variability makes it difficult to chart and generalize about clear patterns over time. However, it is clear that despite the two-doctor rule still remaining in place fifty years later, a 'gap has opened up between law and practice', with doctors becoming 'increasingly liberal in their attitudes to abortion and less inclined to impose barriers to access'.[105] The majority of abortions in England and Wales are now provided by charities, under contract from the NHS, operating with 'an explicitly pro-choice vision'.[106] While the interpretations of individual doctors may still vary, it is significant that in the approach to the fiftieth anniversary of the Act, key medical bodies such as the British Medical Association, the Royal College of Midwives, and the Royal College of Obstetrics and Gynaecology, have all stated their support for the decriminalization of abortion.[107]

In general, the interactions between doctors and women seeking terminations have come to be understood in a more functional way over time. Studies of abortion practice have revealed changing approaches from women as well as medical professionals, with several women giving 'the impression that they were ticking off the consultations in their

[102] S. M. Beynon-Jones, 'Timing is everything: the demarcation of later abortions in Scotland', *Social Studies of Science*, 42/1 (2012), pp. 53–74.
[103] Abortion was 'portrayed as understandable for those patients who are young and/or who lack stable relationships … Conversely, health professionals problematise abortion requests made by "older", childless and/or middle-class women.' S. M. Beynon-Jones, 'Expecting motherhood? Stratifying reproduction in 21st-century Scottish abortion practice', *Sociology*, 47/3 (2013), pp. 509–25, at p. 520.
[104] Sheldon, *Beyond Control*, p, 65.
[105] Amery, 'Solving the "woman problem" ', p. 556.
[106] Sheldon et al., 'Abortion Act'.
[107] Lee et al., '1967 Abortion Act', p. 32.

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minds as necessary hoops through which they had to jump'.[108] There has been a clear shift away from an acceptance of paternalism towards an understanding of the need to accept and respect patient autonomy.[109] This implies that game-playing and performance may have become less pivotal over time, and that the medical interview has become less of an unknown and unpredictable encounter for women. However, women's testimonies of abortion experiences retain important continuities across the period, and an ongoing variability of experiences is clearly evident. It is still demonstrably more difficult for some women to obtain an abortion than others; even if ideas of sympathetic categories have changed over time they have not disappeared. It is important to recognize ongoing barriers for women in accessing terminations through their doctor, which recent studies have made clear.[110] This represents an important reminder of the difficulties and stigma that women in Britain still might face under the conditions of a fifty-year-old Act.

[108] Allen, *Counselling Services*, pp. 172–5.
[109] Sheldon et al., 'Abortion Act'.
[110] A. R. A. Aiken, K. A. Guthrie, M. Schellekens, J. Trussell and R. Gomperts, 'Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain', *Contraception Journal*, 97/2 (2018), pp. 177–83.

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